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State of Wisconsin

Department of Health and Family Services

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RE: Adult Protective Services Modernization Project - Response to WCHSA

Dear Lu and Jack:

Thank you for providing feedback on the Adult Protective Services (APS) Modernization Project Report that was submitted to DHFS Secretary Phyllis Dubé last August. We appreciated your thoughtful comments and the opportunity to talk with you. We recognize that the report's recommendations represent some changes in the existing elder abuse and APS systems. We agree with your commitment to uphold the right to self-determination.

PERCEIVED SHIFT IN APPROACH

We want to first address the perception that the Department is "shifting" from a caregiver stress model to a domestic violence intervention approach. The Department believes that Wisconsin's elder abuse (and related) laws work appropriately for situations of caregiver stress. The APS Modernization Report's recommendations address filling gaps for situations other than those caused by caregiver stress. The proposal recognizes current data showing that domestic violence is an additional cause of elder abuse. In the report we recommend ways to ensure that Wisconsin has protocols and procedures in place that address these situations also.

As you know, there is today a much greater recognition of the incidence of domestic violence in later life than there was when the elder abuse law was passed in 1983. We are now only too painfully aware of the fact that there are many cases in Wisconsin of "domestic violence grown old," as well as cases of domestic violence that first emerge in later life, whether committed by a spouse, partner, child, grandchild, other adult relative or other domestic situation. In addition, we now acknowledge that domestic violence can involve the entire APS population. People with developmental disabilities, those with chronic mental health issues and others may be in situations that mirror "classic" domestic violence relationships. This has led to a recognition of the additional challenge faced by individuals who are abused by caregivers and court-adjudicated incompetent individuals (i.e., wards) who cannot obtain restraining orders on their own behalf.

To reiterate, our goal is not to discard an approach or to replace one theory or model with another; rather, it is to acknowledge that there are a variety of ways and reasons individuals are hurt or harmed. Therefore, it is imperative to have a range of options and constructs available to

ensure an appropriate intervention that is most effective and that neither blames the person being harmed nor puts the person at greater risk of harm. Additionally, we anticipate that the recommendations for increased connections with law enforcement and the criminal justice system will not only enhance our ability to respond to situations of family violence but will also be helpful when addressing the growing concerns of financial exploitation.

BACKGROUND

The Adult Protective Services Committee, first convened in August 2000, included several county social/human services or elder abuse representatives (Dennis Wittig - Columbia; Lu Rowley - Waushara; Melanie McIntosh - Dane; Maria Ledger - Milwaukee) as well as one county corporation counsel (Todd Liebman - Sauk). These individuals' contributions were invaluable both in our discussions and in forging the consensus we ultimately reached on several important issues. One of those areas was reaffirming our commitment to social workers conducting a "social worker intervention," rather than taking the lead in conducting more of a "law enforcement-type investigation" of collecting evidence, interviewing potential court witnesses, etc. That said, the committee recognized that the social worker, in doing his/her intervention, must be careful to not to in any way hamper any later law enforcement investigation (e.g., by tainting physical or testimonial evidence). In addition, it was recognized that there were certain situations when law enforcement should either also be involved or in fact take the lead (e.g. where a crime was being committed or had clearly been committed). This statewide committee also deliberated long and hard before ultimately carving out very narrow circumstances where it believed Wisconsin should require reporting by certain professionals. The situations requiring reporting involve cases where a crime is being committed against an individual or a person is at great risk of imminent danger and/or is incapable of seeking help on their own.

As we look to the future, it is important to acknowledge that "who is reportable" is indeed a large, broad group. However, what, if anything, *happens* to these individuals as a result of a report ultimately results in a significantly smaller number of individuals. The APS Modernization Committee used the visual image of a funnel in understanding this concept: the top of the funnel is "who is reportable," but as the system progresses, different folks sift out. The numbers decrease as competent folks with no great risk decline interventions. Ultimately all that will remain in the system are competent folks who desire services or incompetent individuals for whom services or placement is imposed involuntarily.

RECENT INITIATIVES

As beneficial as it is to reflect on where we are and are going, it is important to recognize the many support initiatives that DHFS has recently commenced. First, of course, is the large infusion of dollars for elder abuse direct services – the largest ever in the history of the law – with over $2 million currently being distributed to the counties.

Second, through the APS Modernization Project, we are looking to increase collaborations and coordination to avoid either duplication or individuals "falling through the cracks," as well as to simply improve efficiencies. Related to this, we have provided each county with both a sample Elder Abuse Interdisciplinary Team Manual and the opportunity to attend one of 17 regional trainings to help in getting each team organized. We are committed to additional training for APS workers, law enforcement, domestic violence programs and others on

many of the recommendations included in the report and we are organizing a state-wide group of local representatives to plan an elder abuse public awareness effort, with all materials ultimately developed made available to counties.

MANDATORY REPORTING

With that as background, we'd like to turn to your major concerns. You have in writing and during our conversations raised concerns about the proposal's recommendation regarding mandatory reporting by specific professionals in certain situations. (Reporting Recommendation 3, pages 15-17, copy attached.) As pointed out, Wisconsin law already, of course, requires reporting in certain circumstances. For example:

(1) Most health care providers (e.g., nurses, physicians, physician assistants, occupational therapists, therapy assistants, podiatrists, respiratory care practitioners, and psychologists) must report gunshot wounds (less than 30 days old), other wounds believed to have occurred as a result of a crime and certain burns. §146.995(2), Wis. Stats. These must be reported as soon as possible to police or sheriff's departments where the treatment is rendered.

(2) Therapists are required, with their patient's consent, to report to the Department of Regulation and Licensing (or the local District Attorney if the therapist isn't licensed) other therapists who allegedly had sexual contact with patients. §940.22(3), Wis. Stats.

(3) Community-based residential facility, nursing home or treatment facility staff must report deaths in their institutions to DHFS's Division of Supportive Living if the death was related to the use of physical restraints or psychotropic medications or suicide. §§50.035(5)(b), 50.04(2t)(b) and 51.64(2)(a), Wis. Stats.

(4) Psychotherapists, and perhaps other mental health professionals, must report "reasonably foreseeable dangerous behavior" to the person who the patient has threatened to harm or the family of the patient. (See *Schuster v. Altenberg*, 144 Wis. 2d 223 (1988).)

(5) Any person witnessing a crime being committed where the victim is exposed to bodily harm is required to notify law enforcement. §940.34(2)(a), Wis. Stats.

(6) Any unlicensed security person, any person licensed as a private investigator or granted a private security permit must report to law enforcement whenever he or she has reasonable ground to belief a crime is being committed or has been committed. §940.34(2)(b), Wis. Stats.

(7) A large host of social service and long-term care providers must report "caregiver misconduct" including abuse, neglect and misappropriation of client property. Reports must be made to DHFS to the Caregiver Registry and Investigation Section of BQA. Ch. HFS 13, Wis. Admin. Code.

- PHYSICIANS

Of course certain professionals have a "professional/patient (or client) privilege" that must be considered as well. For example, physicians, whose patients are entitled to confidentiality (§905.04, Wis. Stats.), recognized the importance of respecting patients' rights and the potential danger to a victim if a report is made without patient consent. The Wisconsin Medical Society, in developing their policy on mandated domestic violence reporting, reflected this concern. The policy states:

"In treating patients who are possible victims of domestic violence, the goal of intervention must be to help victims regain control of their lives. It is, therefore, vital that physicians pay great respect to a patient's right not to disclose domestic abuse or to refuse intervention when the patient believes such action is not in his or her best interest. The role of the physician in this process is to offer patients options and allow them to make the decisions in their lives. The patient's decision should be documented in the medical record."

The policy then notes the circumstances in which intervention **must** occur – *with or without the patient's consent.* These include:

1. If child abuse or neglect (under age 18) is disclosed or highly suspected;
2. If there is a question regarding a patient's mental competency;
3. If there are gunshot wounds or life-threatening injuries;
4. If the physician believes the patient to be at high risk for life-threatening or serious injury.

Interestingly, our project's recommendation is more narrow than the Medical Society's in that ours would require reporting only when the professional believes the adult-at-risk meets the definition of incompetence, or is unable to make an informed judgment about whether to report AND is currently at risk of immediate or serious bodily harm or death or significant property loss.

- ATTORNEYS

Similarly, attorneys' clients are also entitled to confidentiality in their communications. See, Supreme Court Rule 20:1.6(a) and §905.03(4)(a), Wis. Stats. The attorney's rules of professional responsibility do, however, recognize certain exceptions. For example, SCR 20:1.14, *Client Under a Disability*, requires in paragraph (a) that attorneys make every effort to maintain a normal client-lawyer relationship with the client, even when the representation is impaired because of mental disability. However, that rule's subsection (b) states: "A lawyer may seek the appointment of a guardian or take other protective action with respect to a client, only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest." Also, SCR 20:1.6(b) *directs* attorneys to disclose client communications (...a lawyer *shall reveal* the confidential information) when necessary to prevent a client from committing a "criminal or fraudulent act that the lawyer reasonably believes is likely to result in death or substantial bodily harm or in substantial injury to the financial interest or property of another."

- SOCIAL WORKERS

Turning to social workers, the Code of Ethics of the National Association of Social Workers also contains strong provisions on confidentiality, but with notable exceptions in situations of diminished capacity and/or imminent danger. Please note the following sections.

1.01 **Commitment to Clients**...In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised.

1.02 **Self-Determination**. Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. *Social workers may limit clients' right to self-determination when, in the social workers'*

professional judgment, clients' actions or potential actions pose a serious, foreseeable and imminent risk to themselves or others. (Emphasis added.)

1.07 **Privacy and Confidentiality**

...

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. *The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person.* ... (Emphasis added.)

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

1.14 **Clients Who Lack Decision-Making Capacity**. When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

We believe, therefore, that this proposal is merely bringing the adult protective services laws in step with existing statutes. For example, Wisconsin's statute on mandatory arrest for domestic abuse, sec. 968.075, Stats., *requires* law enforcement to make an arrest in certain situations of domestic abuse, regardless of any request not to do so by a victim or others involved. §. 940.32(2)(a), Stats., imposes a criminal penalty on individuals who know a crime is being committed and fail to take action. § 940.295(3), Stats., imposes criminal penalties on individuals at certain facilities who knowingly permit someone else to engage in abuse or neglect. And *Schuster v. Altenberg*, 141 Wis. 2d 223, 434 N.W.2d 159 (1988), held that under some circumstances, professionals have a common law *duty* to release confidential information when necessary to prevent foreseeable harm.

Thus, notwithstanding general rules of confidentiality and informed consent, ethical standards of the three professions cited above (doctors, attorneys and social workers) describe certain situations where the professional, using his or her best judgment, may determine that disclosure is necessary to prevent harm to the client/patient or others. In addition, current statutory and case law compels professionals to divulge information and take certain actions in certain situations. We believe the recommendation addressing these concerns are narrowly drawn to address only such situations and thus is well-sanctioned within current ethical standards and comports with existing law. In other words, we believe these are situations where: (a) most social workers would *want* to be able to report; and/or (b) social workers are already obligated to report and/or (c) there is nothing in current law or ethics that is currently prohibiting social workers from reporting.

- LIABILITY & IMMUNITY

We note also that representatives from a few professional groups have raised concerns that the proposed language may create potential liability from family members or others where a professional evaluated a situation and determined (and documented in the client case record) that a victim might be in greater danger if the professional reported the situation and therefore did not do so. Then if months or years later the adult-at-risk is further harmed, the concerned relatives

could possibly bring an action against that professional for having failed to report. To this end, we are considering language to be added to the proposal, similar to language of § 968.075(3)(a)1.b., Wis. Stats., (domestic abuse mandatory arrest). We would propose language providing that, in determining whether to report, the professional should consider the intent of the law to protect victims of (domestic) violence, the relative degree of injury or fear inflicted on the persons involved and any history of past abuse between these persons, if that history can reasonably be ascertained by the professional. Finally, important to note is the extensive immunities for reporting that the report proposes in Recommendation 13 (page 23). This section provides strong immunities for any reporter, including the professionals listed as mandated reporters in the narrow circumstances described above (Recommendation 3 of the Report). It presumes that individuals acted in good faith in reporting and requires that any "lack of good faith" must be shown by clear and convincing evidence. The immunities cover both reporting and investigating and also specifically include participating in any administrative or judicial proceedings related to a report.

As indicated above, if the recommendation for mandatory reporting in certain situations ultimately becomes law, we plan to provide written materials as well as training to help APS workers, law enforcement and others become more comfortable with this shift. In the meantime, we thought that the following examples might prove helpful to your group. Please note that the examples create scenarios both of situations where a report to APS may or may not be required (under the proposal) as well as situations where an APS report/request to law enforcement may be involved. The situations involving a report/request to law enforcement, are based on Recommendation 6 of the Investigation section of the August 2001 APS Modernization Report (pages 31-32), which are identical to the situations delineated in the sample Memorandum of Understanding (MOU) between county elder abuse lead agencies and law enforcement, distributed by DHFS in 1999.

- SAMPLE CASE SCENARIOS

CLIENT A: Adults-at-Risk worker meets with Client A at Adults-at-Risk worker's office, having been brought there by daughter. Daughter says Client's out-of-work son is now living with mom and allegedly is her caregiver. Client, with fairly advanced dementia, is unable to communicate about the source of her injuries (both old and fresh) that appear inconsistent with a fall. There are broken bones, multiple deep contusions and several deep bruises. Adults-at-risk worker specifically asks Client where bruises came from, if she wants help, etc., but Client unable to track social worker's questions or respond. Daughter will be returning Client (her mother) to her home where the patient's son lives.

> RESPONSE: Adults-at-risk worker must notify law enforcement. This is a situation where the adult-at-risk meets the definition of "vulnerable adult" OR that the adult-at-risk is unable to make an informed judgment about whether to report AND is at risk of immediate or serious bodily harm, death or significant property loss. (Situations b.1 or b.2 of the proposal.) Note: if this was a non-county social worker, must report to county agency, which, if confirm a concern that crime may have occurred, will notify law enforcement.

CLIENT B: Social worker sees Client B in hospital where she is being treated for a broken hip. Client's broken hip is explained by family as from a fall down the stairs. It is not clear whether she fell down the stairs or was pushed. In any event, given her mental state, all have agreed that Client should be transferred to a nursing home. Client is not able to participate in this discussion and she is being transferred pursuant to sec. 50.06, Stats., which requires a physician to certify her "incapacity" to make post-hospital care decisions; hospital has started guardianship petition.

> RESPONSE: No obligation for the social worker (or any other mandated reporter) to report to APS agency because even though the client may meet the definition of "vulnerable adult" or "unable to report," she is no longer at risk of immediate or serious bodily harm, death or significant property loss as she will be moving to a nursing home, not back to the residence where injuries occurred.

CLIENT C: This client, age 78, is brought to social worker's office by his son who is crass, controlling and incredibly disparaging to his father. When you ask about bruises, etc., father just kind of shrugs, and son jumps in with how "clumsy," "forgetful" and "just plain impossible" dad has become. He mentions that dad "makes a big mess for me every day" and can't remember to take his medications, drops things, etc. Son is extremely rough with father. Father winces when you shake his hand and you see bruise marks on his arms. His glasses are twisted and taped at the right stem. When you ask the son to wait in the waiting room and try to speak with dad, you ask him if he feels safe at home and if his son treats him well. Father just continues to shrug and does not directly respond. You tell him you are concerned about his son harming him. You ask him if he is afraid of his son. Father hangs his head and shrugs again. Father is clearly malnourished and does not remember when he last had his medications. When you asked the son about dad's medication, the son said that he is now handling the money and that "other expenses came up this month so dad can't afford the medications right now."

> RESPONSE: Social worker (or any other mandated reporter in this situation) must report to APS because the father is not able to make an informed judgment about whether to report and is at risk of serious harm. (Situation b.2 in the proposal.) Adults-at-risk worker should ask client about referral to law enforcement. If client does not verbally object or otherwise actively protect, the worker should also contact law enforcement.

CLIENT D: This client, age 62, is same situation as above but Client D is clear-headed and says adamantly that he doesn't want anything to happen to his son, and that the situation is "not too bad." He understands worker's explanation that abuse is illegal and that he does not deserve to be harmed. The client specifically says, "please, don't tell anybody about this. This just happened this one time. He's a good son and I'm sure it won't happen again. It's fine really."

> RESPONSE: Reporting is not required – he has made an informed judgment about whether to report.

CLIENT E: Mrs. E., age 81, has lived alone for years and is starting to show signs of decline. She appears malnourished and disheveled: in short, she is clearly self-neglecting. She lives alone, in an apartment for senior citizens. The social worker asks her what she would do in an

emergency and she tells you that she knows she should call 911. Social worker reviews her medications with her and she is not accurate about her medication regime. Social worker tells Mrs. E. she/he is concerned about several issues and wonders if she would permit social worker to call county social services to see if they could bring some help in for her, to enable her to safely keep living alone. She thanks social worker for the concern, but is emphatic that she is doing fine and "has just had a couple rough weeks" but doesn't want any strangers in the house.

RESPONSE: Reporting is not required – she is not a "vulnerable adult" and has made an "informed judgment."

CLIENT F: Same as Client E, except that she doesn't know what she would do in an emergency – says she'd ask her daughter to come over. You know the daughter moved to Arkansas last year. When social worker asks her about getting county social services involved, she just says something about "not needing welfare."

RESPONSE: Reporting is not required. Even though she appears to be a vulnerable adult, not capable of "informed judgment," it appears that she is not at risk of immediate or serious bodily harm or death or significant property loss.

CLIENT/PATIENT G: Age 26, Patient G has cerebral palsy, and needs physical assistance with toileting and bathing. He lives in his own apartment with assistance from come-in, live-in, and weekend attendants. He has good receptive language, but virtually no intelligible speech. Lately, he has been flinching, crying out, and acting fearful when his live-in attendant wipes him. His mother, who is also his guardian, takes him to his doctor for an examination. The doctor finds evidence of severe anal tearing and bruises on his buttocks. Client/Patient G will return to his apartment after the examination. When the doctor asks Client/Patient G if he would like the situation to be reported, he nods "yes." The guardian would rather nothing be reported, because she is fearful of the consequences for him continuing to get the help he needs.

RESPONSE: Physician (or any other mandated reporter finding him/herself in this situation) is required to report to APS agency because the patient has asked the physician to report. (Situation b.4. in the proposal.) The guardian's position is irrelevant. Note: If the patient had answered "no," then the physician would have to make a decision as to whether the patient was a vulnerable adult (if so, report) or "unable to make an informed decision about whether to report" (if so, report) because the serious risk does seem to be present. (This scenario involves a physician; the response would be the same if a social worker was the professional involved.) Once report is received by APS and investigation confirms above, APS should contact law enforcement as it appears that a crime has been committed against the adult-at-risk and because there is risk of (continued) abuse. Note: The physician in this situation would also be required to report directly to law enforcement as a mandated reporter under § 146.995(2), Wis. Stats., in that the physician has identified a wound (severe anal tearing) that is a result of a crime (sexual assault). Thus, the physician would be required to report to both law enforcement *and* APS.

CLIENT H: Client H, age 42, has Down Syndrome. In an interview, her social worker/case manager notes that she has large bright red marks on her upper arms and a laceration on her forehead. Client H says she is "sort of slow" and her special transportation bus driver has a lot of people to drop off from the workshop. The bus driver was trying to get her to hurry today by grasping her arms and pushing her from the back. She tripped and fell against a seat, cutting her forehead. She will no longer be using that transportation service.

RESPONSE: Social Worker/Case Manager is required to report to APS agency because the potential reporter reasonably believes that other adults-at-risk (i.e., other users of this transportation service) may become or continue to be victims of abuse or neglect (a b.3. situation in the proposal). It appears that "H" is neither a "vulnerable adult" nor does she meet the definition of "unable to make an informed decision about reporting," and in any event, there is no "immediate or serious harm" risk since she won't be using that service again – thus this situation would not otherwise be required to be reported. However, because other adults-at-risk may use the service, the social worker (or any other mandated reporter) would be required to report to APS agency.

CLIENT I: Same scenario as H, above, but client rode home not with a specialized transportation service but with a friend of a friend, again, not planning to ride with her again.

RESPONSE: There is no duty to report here because, regardless of whether she was a "vulnerable adult" or "unable to make an informed decision about reporting," the risk of immediate or serious bodily harm or death or property loss is not present – and no other vulnerable adults are at future risk since the "friend of a friend driver" (unless she works for the specialized transportation service mentioned above) does not regularly provide transportation.

CLIENT J: APS worker responds to a report of self-neglect. Upon arrival, worker finds Client J lying in bed, with the bedclothes filthy, urine-soaked and covered with feces. J cannot track questions and is moaning. Four dogs are wandering around the house; their food and water bowls are totally empty. The worker asks J whether she would like some help, such as going to a hospital or other facility for evaluation and assistance. When she brings J a drink of water, J starts to scream, pushes the glass away and begins to flail about. Further attempts at communication prove futile. Additional investigation establish that there is one bottle of ketchup and an opened quart of very sour milk in the refrigerator, a pile of unpaid bills scattered on the dining room table, and several open, empty prescription bottles on the kitchen table and nightstand.

RESPONSE: Worker should contact law enforcement to assist in making an emergency protective placement.

CLIENT K: APS receives a report of suspected physical abuse by a neighbor who says she regularly hears yelling and shouting by an adult son against his father, Mr. K., in the apartment above him. Neighbor has reported that alcoholic son is recently separated from his wife, not working and moved in with his father. Neighbor reports a sudden incidence of UPS packages

arriving at the house, that son's "buddies" arrive nightly with bottles of alcohol and that she has heard gunshots. Neighbor believes son is unstable and has a criminal record. When worker calls the home and speaks with Mr. K., he confirms that his son rarely leaves the apartment and that there are firearms present.

RESPONSE: Worker should contact law enforcement to accompany him or her because worker safety appears to be a serious concern.

CONCLUSION

In conclusion, we want to reiterate our interest in continuing this very important dialogue with WCHSA. We are hopeful that the above information has reduced the concerns you raised on behalf of your members specific to their observation of the proposal's "shift to domestic violence" and the perceived conflict with the proposed mandated reporting and the right to self-determination. We remain interested in hearing your concerns. We hope to have your support for the overall proposal as we go forward toward implementation. We realize the importance of WCHSA's feedback in helping us design various components of the proposal (e.g., appropriate training formats).

Again, thank you for taking the time to share your thoughts. We look forward to continuing a strong working relationship.

Sincerely,

Linda Dawson
Deputy Chief Legal Counsel
Co-Chair, APS Modernization Committee

Jane A. Raymond
Advocacy and Protection Systems Developer
Co-Chair, APS Modernization Committee

Att. APS Modernization Committee Report - Recommendation 3

ATTACHMENT:

APS Modernization Committee, Report to Secretary Dubé, August 2001
Reporting Recommendation 3:

RECOMMENDATION 3: Enact statutory language to encourage more voluntary reporting and to mandate reporting in situations identified below. Also, include language to encourage the development of training programs for both permissive and the new "mandatory" reporters.

NEW 46.90(4)(am) or NEW STATUTE (that would also establish voluntary reporting for adults-at-risk ages 18-59 in addition to current sec. 46.90, Stats., provisions for voluntary reporting of "elders"):

1. Notwithstanding any relevant confidentiality statutes, rules or licensing requirements governing the professions, the individuals identified in a., below, shall make reports to the county lead agency for adults-at-risk (or, as required under HFS 13),[1] if the individuals listed below have reason to believe that there is or has been abuse, neglect, financial exploitation or self-neglect of an adult-at-risk they treat, counsel, serve, etc., in the course of their professional capacity, in any of the situations identified in b., below.
    a. The following individuals are required to make reports in any situation described in b., below.
        (1) employees of entities including: a facility licensed by, certified by, registered with or approved by DHFS, a facility as defined in sec. 647.01(4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, treatment facility, tuberculosis sanatorium or other entity licensed, certified or approved by, or registered with the department of health and family services under secs. 49.70, 49.71, 49.72, 50.02, 50.03, 50.35, 51.08, 51.09, 58.06, 252.073 or 252.076 or a facility under sec. 45.365, 51.05, 51.06 or 252.10 or ch. 142 [Anything covered under HFS 13 – required reporters under caregiver misconduct.]
        (2) employees of financial institutions including: banks and trust companies, savings banks, building and loan associations, savings and loan associations and credit unions. [from sec. 705.01(3)]
        (3) health care providers including: a nurse licensed or permitted under ch. 441, a chiropractor licensed under ch. 446, a dentist licensed under ch. 447, a physician, podiatrist or physical therapist licensed or a physician assistant, an occupational therapist or occupational therapy assistant certified under ch. 448, a person practicing Christian Science treatment, an optometrist licensed under ch. 449, a psychologist licensed under ch. 455, a partnership thereof,
        (4) a corporation or limited liability company thereof that provides health care services, an operational cooperative sickness care plan organized under secs. 185.981 to 185.985 that directly provides services through paid employes in its own facility or a home health agency, as defined in sec. 50.49(1)(a).
        (5) Employees of any agency that is subject to sec. 940.295, Stats.
        (6) Social Workers certified under ch. 457, Stats.
        (7) Counselors certified under ch. 457, Stats.
        (8) Therapists certified under ch. 457, Stats.
        (9) Benefit Specialists under sec. 46.81, Stats.

[1] These are cases where an employee of a regulated entity committed the abuse.

(10) Attorneys, consistent with SCR 20:1.14[2]

b. The required reports must be made in any of the following situations:

(1) The individual has reasonable cause to suspect that a patient seen in the course of professional duties meets the definition of "vulnerable adult" under sec. 940.285, Stats., and the adult-at-risk is currently at risk of immediate or serious bodily harm or death or significant property loss to the particular subject adult-at-risk.

(2) The individual has reasonable cause to suspect that a patient seen in the course of professional duties is an adult-at-risk who is unable to make an informed decision[3] about whether to report AND the adult-at-risk is currently at risk of immediate or serious bodily harm or death or significant property loss to the particular subject adult-at-risk; or

(3) The subject individual(s) (i.e., the potential reporter) has reasonable cause to suspect that other adults-at-risk may become or may continue to be victims of neglect, abuse or financial exploitation by the suspected abuser, including but not limited to situations where the risk is to others who receive support from the human service or health care system (e.g., where the perpetrator is employed as a human service worker).

(4) The adult-at-risk, seen in the course of professional duties, asks the professional to report the situation.

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[2] SCR 20:1.14 states:

Client Under a Disability. (a) When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of minority, mental disability or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) A lawyer may seek the appointment of a guardian or take other protective action with respect to a client, only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest.

[3] This would be defined similarly to the language of 880.01(7m), Wis. Stats., regarding an individual being "not competent to refuse psychotropic medication," such as: the individual is not able to make an informed decision about whether or not his or her situation should be reported after the advantages and disadvantages of reporting have been explained to the individual and one of the following is true: (a) the individual is incapable of expressing an understanding of the advantages and disadvantages of a report being made; or (b) the individual is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to reporting, in order to make an informed choice as to whether a report should be made.